STATEMENT OF CONSIDERATION RELATING TO
907 KAR: 1:835

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 1:835 was held on September 21, 2015, and the following individuals submitted comments at the hearing:

Name and Title	Organization/Agency/Other Entity
Lili Lutgens, Licensed Clinical Social Worker	Therapeutic Intervention Services
Solomon Parker	Therapeutic Intervention Services
Shannon McCracken, Interim Executive Director	Kentucky Association of Private Providers
Jean Russell, Vice President, Developmental Services	Seven Counties Services, Inc.
Chris Stevenson, President and CEO	Cedar Lake

(2) The following individuals submitted written comments regarding 907 KAR 1:835:

Name and Title	Organization/Agency/Other Entity
Lili Lutgens, Licensed Clinical Social Worker	Therapeutic Intervention Services
Melissa Renn Brown, Executive Director Program Director, SCL and MPW Waiver Services	Down Syndrome of Louisville, Inc.
Therapeutic Intervention Services	Therapeutic Intervention Services
William S. Dolan, Staff Attorney Supervisor	Protection and Advocacy
Steve Shannon, Executive Director	Kentucky Association of Regional Programs (KARP)
Tanya L. Dickinson, Program Support Branch Manager/Legislative Coordinator	Department for Behavioral Health, Developmental & Intellectual Disabilities
Jean Russell, Vice President, Developmental Services	Seven Counties Services, Inc.
Jodi Wilson, Regional Director	Kentucky Rescare
Lisa A Chaplin Wise	Communicare
Shannon McCracken, Interim Executive Director	Kentucky Association of Private Providers

Brittany Knoth, Executive Director	Path Forward of Kentucky
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer	REACH of Louisville
Stephen S. Zaricki, MSW, Executive Director	Community Living, Inc.
David Coons	Family Home Provider
Meghen Wilson	Growing Minds Learning Center
Jenifer C. Frommeyer, Executive Director	Dreams with Wings
Leah F. Campbell, JD, Chief Operating Officer	Apple Patch Community
Tomika H. Cosby, Executive Director	Kentucky Case Management
Steve Frommeyer, Parent of waiver services participant	
Leigh Denniston	Almcare
Diane Quarles-Hartman, BS/MHA, Executive Director	Evergreen Life Services
Pamela J. Millay, R.N., J.D, Clinical Director/CPO	Redwood
Myra Gribbins, Owner/Executive Director	Reach for the Stars Case Management
Brad Schneider, Vice President Developmental Services Division	LifeSkills, Inc.

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 1:835:

Name and Title	Organization/Agency/Other Entity
Deborah Bailey, Nurse Consultant Inspector	Department for Medicaid Services, Division Division of Community Alternatives
Lyris Childs, Medicaid Services Specialist III	Department for Medicaid Services, Division of Community Alternatives
Earl Gresham, Assistant Director	Department for Medicaid Services, Division of Community Alternatives
Stuart Owen, Regulation Coordinator	Department for Medicaid Services, Commissioner's Office
Jonathan MacDonald, Internal Policy Analyst III	Department for Medicaid Services, Commissioner's Office

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Support Broker Definition

(a) Comment: William S. Dolan, Staff Attorney Supervisor, Protection and Advocacy, made the following comment:

“Section 1 defines a "Support Broker" as someone from an agency designated by the department. This means that MPW participants that chose to participant direct their services must use a support broker from either a Comprehensive Care Center or Area Development District. We suggest allowing consumers, like in SCL, to choose any support broker (case manager) willing to serve that consumer subject to the conflict-free rules. We also recommend that private providers be allowed to furnish the support broker service.”

(b) Response: In the current regulation, DMS contracts specifically with the fourteen CMHC's to provide assessments for individuals seeking to be enrolled in the Michelle P. waiver program. The consumer directed option was limited to only receiving support broker services from the CMHC's only. DMS will take this into consideration for the Michelle P. waiver renewal.

(2) Subject: Eligibility

(a) Comment: William S. Dolan, Staff Attorney Supervisor, Protection and Advocacy, made the following comment:

“Participant enrollment is in Sections 3 and 4. Will the Cabinet use a separate eligibility evaluation tool for children (applicants under age 18)? It's our understanding that over half of the MPW recipients are children.”

(b) Response: At this time, the Cabinet will continue to use the MAP-351 to assess participants and does not have a separate assessment tool for children. The Cabinet will be looking into more age-appropriate tools but has not made a change at this time.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Historically individuals with ID/DD birth to 3 years of age have been denied LOC and referred to the early intervention programs. Should the criteria reflect an age requirement of 3 years?”

(b) Response: The Michelle P. waiver regulation cannot put in age requirements because that was not stated in the original law suit. Any changes that were not stated in the original law suit would be subject to court approval. Pg 18 line 12 - 15; Dept. shall not determine that an individual fails to meet Michelle P. waiver service level of care solely due to the individual’s age.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of

Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Providers acknowledge that the children currently in the Michelle P Waiver and on the waiting list need and deserve supports. Kentucky must find a way, whether in an autism waiver or some other program to meet those needs, and restore the Michelle P Waiver allocations to the adults with I/DD, who would otherwise meet ICF level of care."

(b) Response: The Cabinet cannot consider a new waiver without appropriation of funds and approval of a waiver application from the Centers for Medicare and Medicaid Services (CMS).

(3) Subject: Medicaid Waiver Management Application

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, made the following comment:

"The Kentucky Association of Regional Programs, Inc. (KARP) represents 11 of the 14 Community Mental Health Centers (CMHCs) throughout the Commonwealth. The CMHCs serve and support over 180,000 Kentuckians each year. We appreciate the opportunity to submit comments regarding 907 KAR 1:835. Michelle P waiver services and reimbursement

The Medicaid Waiver Management Application is referenced extensively throughout the amended Michelle P waiver regulation It appears it is becoming the official record for the participant. This issue has been raised previously and concerns persist about whether or not the MWMA is the primary record. If it is not, will the MWMA record interface with providers' electronic health record and billing software thereby preventing unnecessary record and billing duplication. Also, how will credentialing organizations such as the Joint Commission (formerly JCAHO) and GARF review MWMA records during an accreditation review?"

Jean Russell, Vice President, Developmental Services, Seven Counties Services, Inc., stated the following:

"The MWMA system was mandated by CMS to be a mechanism for individuals to enroll in a waiver program. Currently, the state continues to expand the requirements of what must be included in this system resulting in much duplication of effort and

documentation for each provider. On page 6 of this regulation it states, “A clinical record in the MWMA portal for each participant shall contain”. Previously, DAIL and Medicaid have indicated that the MWMA is NOT the clinical record and therefore all providers are having to duplicate work by maintaining two EHR’s for their consumers. This duplication of effort has significantly increased cost for the providers. It is requested that if all clinical documentation for the MPW consumer is to be maintained in the MWMA portal that the state accept this as the medical record and not require duplicate documentation to be maintained by the providers. Another solution would be to utilize the MWMA system as only an application portal and not require other clinical documentation to be included in this system.”

Lili Lutgens, Licensed Clinical Social Worker, Therapeutic Intervention Services, made the following comment:

“As with proposed regulation 907 KAR 12:010,proposed regulation 907 KAR 1:835 requires MPW providers to maintain client records in the MWMA data base pg.12 line 10 including documentation of "each contact with, or on behalf of, a participant." pg.13 line 8. Proposed regulation 907 KAR 1:835 further requires "Documentation of each service provided" be included In MWMA as well. pg.13 line 11. Just as we are concerned with the cost of and inefficiency of requiring providers to maintain two medical records for each participant In the SCL program, we are equally concerned with this requirement in the MPW program. Again we respectfully request that the state decide if they want to maintain a centralized database into which all MPW records including contact date and notes are uploaded, which database they maintain and from which they fulfill record requests, or If they want MPW providers to maintain separate records without the requirement that all documents, specifically contact dates and notes, be uploaded into the state MWMA.”

(b) Response: We apologize for the misinformation – the MWMA is not mandated by the Centers for Medicare and Medicaid Services. The MWMA is an expansion of the Kentucky Office of the Health Benefit and Information Exchange (KOHBIE) end-to-end eligibility and enrollment system launched in December 2013. The MWMA will enable state government staff to view applications, assessments, plans of care, and services for an individual in one consolidated place. It will automate processes that are currently some of the most time and labor intensive for case managers as well as streamline the enrollment process to remove some of the barriers to enrollment.

For Medicaid 1915(c) home and community based waivers, the MWMA will also facilitate the person-centered planning process and implemented a standardized process for plans of care.

The next release of the MWMA includes the ability to record service notes for every service within MWMA. Currently, providers must provide the notes to case managers. When they enter them directly in MWMA, they will no longer separately have to send them to case managers.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Will providers be required to maintain a physical chart as all the necessary documentation will be uploaded to MWMA?”

(b) Response: Information will be maintained in MWMA as long as an SCL provider is actively supporting an SCL participant and has access to all records required for that participant, paper copies are not required. However, providers are required to maintain records for six years. Therefore the agency will need to develop a mechanism for maintaining access to a participant’s records for that timeframe even though the records may not be accessible through MWMA if the participant is no longer supported by that provider at any point in time.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“This section implies that all service documentation be uploaded to MWMA however there is no mention of that in the section regarding services 6 covered services. Please clarify.”

(b) Response: We apologize for the misinformation – the MWMA is not mandated by the Centers for Medicare and Medicaid Services. The MWMA is an expansion of the Kentucky Office of the Health Benefit and Information Exchange (KOHBIE) end-to-end eligibility and enrollment system launched in December 2013. The MWMA will enable state government staff to view applications, assessments, plans of care, and services for an individual in one consolidated place. It will automate processes that are currently some of the most time and labor intensive for case managers as well as streamline the enrollment process to remove some of the barriers to enrollment.

For Medicaid 1915(c) home and community based waivers, the MWMA will also facilitate the person-centered planning process and implemented a standardized process for plans of care.

The next release of the MWMA includes the ability to record service notes for every service within MWMA. Currently, providers must provide the notes to case managers. When they enter them directly in MWMA, they will no longer separately have to send them to case managers. DMS is filing an “amended after comments” regulation that adds the MWMA requirement for other services.

(a) Comment: Therapeutic Intervention Services made the following comment:

“Who is primarily responsible for the setting up and maintenance of the records required in the MWMA system, case management agencies or service providers? If the expectation is for providers to maintain records in the MWMA system, then providers should not have to maintain a duplicate record keeping system. It is redundant and costly. Is there any ability for the MWMA to interface with a provider’s Electronic Medical

Record? There is no clear language in the regulation for Providers maintaining their own records."

(b) Response: The provider agency will be responsible for ensuring access to all records required for reviews. With the next release each provider will be able to enter their agency documentation in MWMA. Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

MWMA contains an electronic record that is available to the provider while they are providing a service to the individual. The electronic record will not be available to the provider when they do not provide a service. Due to record retention requirements providers will need to have a process for maintaining a record when no longer providing the service. At this time MWMA does not interface with individual provider electronic medical records (EMR) systems.

While there is the ability to enter some health information in the accompanying data and documents section of MWMA, MWMA is a waiver long term services and supports system application and does not meet the criteria for Certification Commission for Healthcare Information Technology (CCHIT) or Office of the National Coordinator for Health IT - Authorized Testing and Certification Body (ONC-ATCB) certification of a Long Term and Post-Acute Care(LTPAC) Electronic Health Record.

Although not ready for the scheduled December 2015 release the vision is for MWMA to follow interoperability standards to exchange information via the Kentucky Health Information Exchange (KHIE). Onboarding to KHIE will give a provider the ability to exchange electronic health information between entities that are also part of the information exchange, unlike the limited functionality of an interface, exchanging information through KHIE provides access to acute care facilities, behavioral health, medical providers, or any other provider/agency connected to the exchange.

In the future KHIE will connect to the national exchange allowing exchange of information nationally. Although LTPAC electronic health record (EHR) interoperability is in the beginning stages, the Office of the National Coordinator for Health Information Technology is starting to develop a set of standards for LTPAC, specifically an LTSS information exchange (eLTSS) standard, of which Kentucky is a participating pilot state.

All initiatives are in piloting phases but the LTSS community is certainly a large part of the Health Information Technology (HIT) interoperability roadmap.

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 4 Participant Eligibility Determinations and Redeterminations, "(b) Complete and upload into the MWMA portal a MAP - 115 Application Intake - Participant Authorization.":

"Currently, the MAP 621: MPW Waiting List Application is being completed and faxed to

Carewise to place a participant on the MPW Waiting List. The MWMA system has an option to complete an application within the system but has extensive questions that the Map 621 does not and takes approximately 30 minutes to complete with the applicant and requires disability documentation to be uploaded once all questions are answered. This reference is made to a MAP 115 to be completed and uploaded. Will the Map 621 continue to be completed and faxed in? Will the MWMA Application that is in the system still be utilized? Will the regulation language be modified to require the documentation of disability at the time of application if the MWMA system requires it to upload?"

(b) Response: The MAP 621 is being terminated because it duplicates the new application process. Individuals will be routed as necessary to the Michelle P. waiver program capacity reviewer for placement on the waiting list.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Medicaid Waiver Management Application, a project being developed and implemented by Deloitte, is referenced in nearly every service section of the proposed regulation.

The rollout for MWMA for Case Managers has been unsuccessful and chaotic. Providers cannot seek advice from their Quality Administrators, as they aren't familiar with the system. Case Managers were trained directly by Deloitte and their project manager and help desk assistants are our only resource for answers and help. They do not understand the differences in each waiver, leaving case managers frustrated and without answers. The deadlines for implementation have been delayed repeatedly, including the last one targeted for September 1st because the system is not ready, problems are unresolved and many participants cannot be transitioned for various reasons. One example is that some participants have wrong addresses, which have to be changed through KAMES, which they have to work with DCBS to resolve. This can take hours and multiple phone calls to get one person's address changed. KAPP has attempted to work with DCBS for answers. The resolution of the problem will not happen overnight. KAPP requests that DCBS designate personnel specifically to assist in this process."

(b) Response: Deadlines for case managers to transition waiver participant information into MWMA have been extended because not all case managers completed the transition within the initial deadlines. The wrong addresses are not caused by MWMA. The addresses are what are currently stored in the Kentucky Automated Management Eligibility System (KAMES), which is why they have to be resolved through KAMES. Contact Member Services or the Social Security office if they have Social Security Income (SSI).

As of October 2, 2015 there were more than 20,000 members uploaded into MWMA.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“In the transition process, there have been 2 major HIPAA breaches, which allowed all case managers in the state to view the Private Health Information of every participant in the system, across the state. The first was on April 24th, and the second on September 14th. Both were reported to the Cabinet as well as Deloitte. Both times, only Deloitte responded with a patch to fix the problem, but we received no answer from the Cabinet on how to address the HIPAA Breach.”

(b) Response: The Cabinet Health and Family Services (CHFS) Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer conducted an investigation of two suspected breaches and determined that NO breach occurred.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO

Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Since the Deloitte timeline for MWMA has not been successful (and still is not ready) for Case Management, it seems impossible that the next phase will be ready by December for other service providers to use. The inclusion of entry into MWMA all throughout the regulation seems very premature and unlikely to comply with.”

(b) Response: Deadlines for case managers to transition waiver participant information into MWMA have been extended because not all case managers completed the transition within the initial deadlines. The wrong addresses are not caused by MWMA. The addresses are what are currently stored in Kentucky Automated Management and Eligibility System (KAMES), which is why they have to be resolved through KAMES Contact Member Services or the Social Security office if they have SSI.

As of 10/2/15 there are more than 20,000 members uploaded into MWMA.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Using MWMA for MPW records should be voluntary, not mandatory. Also, it will be nearly impossible to have portal access at all service locations. The Cabinet needs to reevaluate the project including its security. Providers should not be held to a higher standard of HIPAA compliance than the Cabinet.”

(b) Response: Thank you for your comments. DMS is not changing the requirement at this time but will consider the recommendation during the waiver renewal process next year.

(4) Subject: Participant Directed Services

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, made the following comment:

“It is recommended Section 7. Participant Directed Services, subsection (1) (d) 3. be amended by including new language, the amended language is listed below:

3. Include withholding local, state and federal taxes as prescribed by the taxing authority and at the written direction of the participant or the participant's representative and making payments to appropriate tax authorities on behalf of a participant;

The above change will clarify that the withholdings are at the discretion of the participant or their representative and the financial management agency is following their written directions.”

(b) Response: Thank you for your comments. DMS is not adopting the recommendation at this time but will consider the recommendation during the waiver renewal process next year.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Historically, only participants with CDO or Blended plans have been able to receive goods and services (namely incontinent supplies). This is a hardship for many families receiving traditional services and some families have opted to switch plans (contrary to the principles of freedom of choice) in order to receive incontinent supplies, as they were unable to afford them. This should be offered on the traditional service plan as well.”

(b) Response: Thank you for your comments. DMS is not adopting the recommendation at this time but will consider the recommendation during the waiver renewal process next year.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD,

Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“A 40-hour weekly service allotment is not always sufficient. Especially if we are trying to support someone living independently in his or her own home. Could utilize the concept of Exceptional Rate Protocol.”

(b) Response: Thank you for your comments. DMS is not adopting the recommendation at this time but will consider the recommendation during the waiver renewal process next year.

(5) Subject: Non-PDS Provider Participation Requirements

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Compliance with SCL section 3 of the 907 KAR 12:010 regulations were removed however there are no replacement for any compliance or policies and procedures. The removal of this section also removed all the background check requirements such as the AOC, Nurse Aide, etc.”

(b) Response: The background check requirements are listed in 906 KAR 1:190, which includes use of the Nurse Aide Abuse registry and the Child Abuse and Neglect registry among others - Section 1(8)(a-d). 906 KAR 1:190 also includes criminal background checks - Section 4.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Non PDS Providers no longer have to complete an AOC or nurse aid background check for employees? The only required check is the Caregiver Misconduct Registry?”

(b) Response: Non-participant directed service (PDS) providers will comply with the Caregiver Misconduct Registry and regulation 906 KAR 1:190 for background check requirements. According to 906 KAR 1:190 - Section 1(8) - Registry is defined as follows:

“(8) "Registry" means the:
(a) Nurse aide abuse registry maintained pursuant to 906 KAR 1:100 and 42 C.F.R. 483.156;
(b) Child abuse and neglect registry maintained pursuant to 922 KAR 1:470 and required by 42 U.S.C. 671(a)(20);

(c) List of Excluded Individuals and Entities maintained by the United States Department of Health and Human Services, Office of Inspector General pursuant to 42 U.S.C. 1320a-7; and
(d) Any available abuse registry, including the abuse and neglect registries of another state if an applicant resided in that state."

(a) Comment: Solomon Parker, Therapeutic Intervention Services, stated the following:

"My overall concern with Michelle P. 9 Waiver regulation is the fact that as it reads right now, it's pretty much cut and paste. They did everything they could to remove the Supports for Community Living Waiver out of the regulation, but they didn't supplement it back with anything that's pertaining to – anything administrative to this regulation.

For example, if you look at the regulations closely, the proposed regulations, for Michelle P., the only required background check is the Kentucky Caregiver Misconduct for traditional providers. There is nothing in there listed about staff requiring to have first aid, CPR. There's nothing in there requiring that you can't hire anybody with a felony, drug tests. None of those things are included in this regulation.

So, for me, in addition to some other things that's listed in my comments that I've submitted, this regulation presents as being incomplete and overall has tremendous health, safety, welfare concerns for the participants in our programs if it's not fully completed and looked at closely rather than just being cut, pasted and edited to meet the new federal guidelines."
Therapeutic Intervention Services stated the following:

"Upon the removal of references to the Supports for Community Living waiver, the proposed Michelle P. Waiver regulations are incomplete. Rather than revamping the regulations to include elements referenced in the Supports for Community Living waiver. The Cabinet has simply cut and pasted regulations to meet the Federal Final Rule. For example, in section 2 of the regulations, the only background check that is required of a Michelle P. Waiver provider is the Caregiver Misconduct Registry. Below is a list of a few other essential health, safety, and welfare elements the Cabinet failed to include in the proposed Michelle P Waiver regulations for a traditional provider:

- Necessary background checks to be complete before hire (i.e. Central Registry Check, Kentucky Nurse Aide Abuse Registry, Administrative Office of the Courts, TB Skin Test, or Drug Test}. Per these regulations, a traditional provider can hire a staff person with a felony conviction, drug charges, DUIs, active TB, and positive drug tests.
- Establishing the responsible authority figure within the agency, i.e. the Executive Director.
- For persons to be trained on an individual prior to working with them independently.
- For persons to complete First Aid and CPR prior to working with a person independently (only reference is in the mortality review in Section 11).
- Training on medication administration prior to working with an individual independently.

Recommend for the Cabinet to look at the administrative requirements for the Michelle P. Waiver before approving and enforcing the regulation. As of right now, this portion of the regulation is incomplete and poses tremendous health and safety concerns for participants supported in the Michelle P. Waiver."

(b) Response: DMS is filing an "amended after comments" regulation which reinserts references to the SCL provider requirements and also inserts, for participant directed service (PDS) providers, a central registry check requirement as well as clarifies that a criminal background check must be one from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to being a PDS provider.

(a) Comment: Tanya L. Dickinson, Program Support Branch Manager/Legislative Coordinator, Department for Behavioral Health, Developmental & Intellectual Disabilities stated the following:

"Comment:
The regulation stipulates that providers shall be certified "at least" biennially by the department. Does this mean that providers may be certified or recertified more frequently as a result or consequence of a CAP, or for other causes?

Recommendation:
Yes. According to the schedule below, recertification lengths should be re-assessed at the scheduled recertification date and based on: citations identified during a recertification review; citations issued during the prior twenty-four (24) month period; submission of an approved CAP (or revision); successful implementation of an approved CAP (or revision); repeat citation(s); Health/Safety/Welfare Citations; and other significant issues identified by the department.

Provider Status (at Recertification Date)	**Certification Period**
• Zero (0) citations during the prior twenty-four (24) month period	Two (2) Years
• Zero (0) citations during the most recent recertification review • Successfully implemented the approved CAP for any citations issued during the recertification period.	One (1) Year
• Received citations during the most recent recertification review • Existing (open) citations without either an accepted CAP or a	Six (6) Months • Upon approval of CAP, department will monitor for successful implementation within 30 days • Upon successful implementation of CAP,

successfully implemented CAP	department may extend recertification to balance of one year • If provider fails to implement an approved CAP, department may extend timeframe for implementation or recommend non-renewal or termination to DMS If provider has not submitted an approved CAP after the three (3) allowed attempts (see above), department will recommend non-renewal or termination to DMS

(b) Response: DMS is filing an "amended after comments" regulation which adds the following provisions:

Section 16. Provider Certification. The following shall apply regarding Michelle P. waiver provider certification periods:

Provider Status at Recertification Date	New Certification Period Based on Status at Recertification Date
Zero (0) citations during the most recent recertification review and have successfully implemented any approved corrective action plan for any citation issued during the recertification period if any citation was issued	One (1) year

Received citations during the most recent recertification review or has existing (open) citations without either an accepted corrective action plan or a successfully implemented corrective action plan	Six (6) Months (1) Upon approval of corrective action plan, the department shall monitor for successful implementation within thirty (30) days. (2) Upon successful implementation of corrective action plan, the department shall extend recertification to balance of one (1) year. (3) If provider fails to implement an approved corrective action plan, the department shall extend the timeframe for implementation or recommend non-renewal or termination to the department. (4) If provider has not submitted an approved corrective action plan after the three (3) allowed attempts (see above), the department shall consider non-renewal or termination.

(6) Subject: Waiver Amendment

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“The O-Regs for MPW do not reflect any of the changes in the CMS approved waiver amendment for MPW.”

(b) Response: The Michelle P waiver is up for renewal in September 2016 and any necessary changes to the waiver will be made at that time.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Supported Employment – The reimbursement rate does not reflect the waiver amendment rate increase that was submitted to CMS.”

(b) Response: The Michelle P waiver is up for renewal in September 2016 and any necessary changes to the waiver will be made at that time.

(7) Subject: Assessment

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“In the interested of being person centered, reassessment should be able to occur in other places other than in the home to include the person centered service plan team’s impute.”

(b) Response: Per the current Michelle P. waiver regulation one face-to-face visit must occur in the home monthly. Requiring at least one face-to-face visit by a member of the assessment team during the assessment/reassessment process does not preclude one or more members of the team visiting the individual setting out of the home.

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment regarding Section 6 Covered Services Assessment and Reassessment, (3) Covered Michelle P. waiver services shall include: (a) A comprehensive assessment which shall: l. Be completed by the department:

“Currently, MPW assessments and reassessments are being completed by the CMHCs. Will this process change? It is also stated under Section 7 that, ‘(16)(a) A support broker or case manager may conduct an assessment or reassessment for a PDS participant.’ Please clarify.”

(b) Response There will be no changes to the regulation regarding this at the present time.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“The Map 351 is not an appropriate assessment tool for children and alternate assessments should be use for specific age groups to accurately depict need and level of care.”

(b) Response: At this time, DMS will continue to use the MAP-351 to assess participants and does not have a separate assessment tool for children. DMS will explore more age-appropriate tools but has not made a change at this time.

(8) Subject: Case Management

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“In the interest of person centered and for monitoring purposes of all services provided to a participant, Monthly Face-to-Face visit should be able to occur at or in any cite in the community.”

(b) Response: Per the current Michelle P. waiver regulation, the case management requirements state that the monthly face-to-face visit has to be done in the home, adult day health care (ADHC) center, or day training provider location. The case manager is permitted to visit the individual in any setting but at least one face-to-face must occur at least monthly in the sites previously noted.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Case Management - should be reflected at one unit of service for a flat monthly service fee as other waivers and Support Broker services have adopted.”

(b) Response: DMS is not adopting the recommendation at this time but will consider it during the waiver renewal process next year.

(a) Comment: Therapeutic Intervention Services made the following comment:

“Remove the requirement for face-to-face contact to occur only at the Adult Day Health Care Center, Adult Day Training Center, or individuals home. A large number of Michelle P. waiver recipients are of school age, which means they do not utilize ADHC or ADT services. These children, who make up 70% of the waiver, use CLS and Behavior Supports. If a Case Manager's responsibility is to monitor the services and supports the individual receives, then that is difficult to do if they are required to have a face-to-face in the home.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Some other specific questions/comments from KAPP members regarding this proposed regulation:

• Remove the requirement for face---to---face contact to occur only at the ADHC, ADT, or participant’s home (which is NOT a service site.) A large number of Michelle P. Waiver recipients are of school age, which means they do not utilize ADHC or ADT services. These children utilize primarily CLS and Behavior Supports. If a Case Manager’s responsibility is to monitor the services and supports the person receives, then that is difficult to do if they are required to have a face---to---face in their home. Again, residential is not a covered service. Request that the face---to---face site description mirror that of the SCL waiver.”

(b) Response: Thank you for your comment. DMS is not adopting the recommendation at this time but will consider it during the waiver renewal process next year.

(a) Comment: Jean Russell, Vice President, Developmental Services, Seven Counties Services, Inc., stated the following:

“There is lack of clarity regarding Conflict Free Case Management and a consumer electing PDS. If a consumer selects PDS then this consumer should be allowed to select any provider they choose even if that includes selecting a support broker and other services from the same entity. Need this clarified.”

(b) Response: Please see Section 9(5)(a) and (b) which states:

“(5)(a) Case management for any participant who begins receiving Michelle P. waiver services after the effective date of this administrative regulation shall be conflict free except as allowed in paragraph (b) of this subsection.

(b)1. Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified Michelle P. waiver provider within thirty (30) miles of the participant’s residence.”

(a) Comment: Jean Russell, Vice President, Developmental Services, Seven Counties Services, Inc., stated the following:

“There needs to be clarification regarding case management entities offering services under PDS. If these agencies wish to offer this service they should also be required to provide the Financial Management Services. It is not appropriate to mandate other FMS providers to provide this service to a separate entity. There is significant cash flow and claim issues that put the separate FMS provider at risk with little or no venue for recouping funds. We request the state require any entity providing Support Broker services to also provide the associated FMS services.”

(b) Response: Thank you for your suggestions. DMS is not adopting the recommendations at this time but will consider them during the waiver renewal process next year.

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 7 Participant Directed Services 15) A support broker shall:(a) Provide needed assistance to a participant[consumer] with any aspect of PDS[CDO] or blended services; (b) Be available to a participant[consumer] twenty-four (24) hours per day, seven (7) days per week; (c) Comply with all applicable federal and state laws and requirements; (d) Continually monitor a participant's[consumer's] health, safety, and welfare; and (e) Complete or revise a person-centered service plan in accordance with

Section 8 of this administrative regulation [of care using the Person Centered Planning: Guiding Principles].

“Will the Support Broker also be required to be 'conflict free' as it is not specified in this regulation?”

(b) Response: Yes, and DMS is filing an “amended after comments” administrative regulation which will clarify this.

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 9 Case Management Requirements 1.A monthly department approved person-centered monitoring tool;.:

“What tool is referenced in this section and when will training for use of this tool occur? What is the date this tool will be required to be utilized following appropriate training for use of this tool?”

(b) Response: The MAP 109 was replaced by the person-centered service plan. The department will monitor the entries of the person-centered service plan made by the case managers into the MWMA.

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 9 Case Management Requirements (b) l. Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 191S(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified Michelle P. waiver provider within thirty (30) miles of the participant's residence.:

“Is the 30 miles to the participant's residence from the address of the assigned Case Manager or from the Case Manager Agency Address?”

(b) Response: The 30 miles is in reference to the case manager’s distance from the participant and does not pertain to the distance between the agency and the participant.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO

Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Specifically, the issue of Case Management Face---to---Face visits: the regulation requires that they occur either in the participant's HOME, ADT or ADHC. That's it. Case Managers have been asking questions about monitoring in the community, during therapy sessions, during CLS activities, etc. Many people get Case Management and Behavior Supports, for instance. The Cabinet cannot or should not require that every participant attend an ADHC or ADT? What about CLS, Supported Employment, etc.?

Add to the equation that there are over 2,000 children UNDER 16 years of age in the waiver currently, and ADT/ADHC is only available for age 16 and up! We have a problem."

(b) Response: Thank you for your comment. DMS is not making any changes at this time in response to the comments but will consider them when renewing the waiver next year.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"• The 15---minute unit at 4 units per month does not accurately encompass the duties of a case manager. The cabinet should consider a flat monthly billing rate (such as in other waivers) and a face---to---face monthly contact at any service site. The home or ADT setting is extremely limiting and does not allow for an accurate picture of the person and their supports."

(b) Response: Thank you for your comment. DMS is not adopting the recommendation at this time but will consider it when renewing the waiver next year.

(9) Subject: Personal Care Service

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Define “Age-Appropriate.” If this service is specific to adults define an age requirement.”

(b) Response: Age appropriate means “the same as for peers not currently receiving Michelle P Waiver services who are the same chronological age.”

DMS will consider adding definition during the waiver renewal process next year.

(10) Subject: Ancillary Services

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“OT, PT and ST. Are these services not covered by EPSDT or the State Plan? If so this is a duplication of service by CMS standards. If they are not covered by one or the other it should reflect the necessary age restrictions according the EPSDT and the State Plan.”

Jean Russell, Vice President, Developmental Services, Seven Counties Services, Inc., stated the following:

“We are requesting clarification regarding the ability to provide Occupational, Physical and Speech Therapy through this waiver. These services are still included in this amendment yet the state has indicated that these services will no longer be available through this waiver. Please clarify, will these services be available through this waiver until such time of the renewal? Additionally, please clarify if these services are available to individuals regardless of age, since the waiver does not indicate any limitation.”

(b) Response: DMS is not reducing coverage of therapies as waiver participants who previously/currently receive them as a waiver program benefit will be able to receive them as a state plan benefit. Thus, though DMS expenditures on therapies as a waiver benefit will drop DMS expenditures on therapies as a state plan benefit will increase proportionately.

(a) Comment: Therapeutic Intervention Services made the following comment:

“Remove the monthly summary requirement for Physical and Speech Therapy and replace them with a detailed staff note just like Occupational Therapy.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD,

Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Remove the monthly summary requirement for Physical and Speech Therapies and replace them with a detailed staff note just like Occupational Therapy.”

(b) Response: Thank you for your suggestion. DMS is not adopting the recommendation at this time but will consider it during the waiver renewal process next year.

(11) Subject: Supported Employment Service

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“List the approved Training. Ie Supported Employment Training Project.”

(b) Response: There has been no change to the provider supported employment training.

(12) Subject: Reimbursement

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Clarify if this applies to Non-PDS only, PDS only, or in combination of both Non-PDS and PDS.”

(b) Response: The limit does indeed apply to non-PDS and PDS:

“The following Michelle P. waiver services alone or in combination shall be limited to forty (40) hours/week.”

This applies to both PDS and non-PDS.

(13) Subject: Respite

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Respite services should be based on certification year and not calendar year.”

(b) Response: Respite services for traditional Michelle P. waiver services are based on a calendar year. Respite services for PDS are based on a certification year. DMS will clarify this during the waiver renewal process next year.

(14) Subject: Termination Requirements

(a) Comment: Lili Lutgens, Licensed Clinical Social Worker, Therapeutic Intervention Services, made the following comment:

"As with the SCL regulation, the MPW regulation, in cases in which the guardian and/or client disagree with a provider's decision to end services, requires the MPW provider continue services until a substitute provider is found. pg.16 line 6. As noted above, however, this creates a situation in which providers, specifically individuals providing PBS or CLS, are forced to continue services in cases in which goals have been met because the family is fearful of letting go of services and in other cases in which the client and/or family is chronically non-compliant and no progress is being made. This is a waste of the State's resources and thus we respectfully request that these two services, PBS and CLS be excluded from this requirement of the regulation such that these services can be terminated where the clinician deems that the service is no longer necessary and/or the participant or family is evidencing a pattern of non-compliance."

(b) Response: The current termination language is meant to address provision of services that are necessary but the team has concluded that a change of provider for a specific service is necessary. In this scenario the present provider would continue services until a new provider is determined so that a sound transfer can occur. If the reason for termination is that the support provided is no longer necessary, the provider would process a modification of service plan.

(a) Comment: Tanya L. Dickinson, Program Support Branch Manager/Legislative Coordinator, Department for Behavioral Health, Developmental & Intellectual Disabilities stated the following:

"Comment:

907 KAR 7:005, Certified waiver provider requirements, requires that the department offer a provider a "voluntary moratorium" while it conducts an investigation as an alternative to immediate termination of provider certification in the event reliable evidence leads the department to believe that a certified provider has committed a violation that threatens the health, safety or welfare of a recipient. The voluntary moratorium will remain in effect through the CAP development, review/approval process, and implementation. However, there is no specified process in this regulation for: formally ascertaining a provider's acceptance of the voluntary moratorium; the specific circumstances of its imposition (e.g., start date, alternatives/consequences); or the department's actions if termination should occur.

Recommendation:

Upon notice of the potential health, safety or welfare violation, the Department shall contact the provider's Executive Director to officially notify the agency of the option for Voluntary Moratorium and to discuss the health, safety, or welfare concern(s). The department's notice to the provider shall be by phone followed by electronic means.

Upon receipt of electronic notice, the provider shall either formally accept (agree) or not accept (not agree) the option for Voluntary Moratorium by signing the provided document, and returning it to the department within two (2) business days of receipt via electronic means as directed in the electronic notice.

If Voluntary Moratorium is accepted by the provider, the department will continue proceedings as required by 907 KAR 7:005. If Voluntary Moratorium is NOT accepted by the provider, the department will work in conjunction with DMS to continue proceedings as required by 907 KAR 7:005, and notify the provider's Executive Director at the agency's primary business address, in writing, of the reason for termination and the provider's right to appeal the termination within two (2) business days of receipt of the written non-acceptance of the option for Voluntary Moratorium, or within five (5) business days of the initial notice sent to the provider, if the provider does not respond to the notice of the option for Voluntary Moratorium. The notice of termination to the provider will be sent via delivery service that records both sending and receipt (e.g., certified mail, overnight delivery service).

In the event of termination, the department's role is one of monitoring the agency's efforts to ensure the health, safety and welfare of individuals and providing technical assistance during the transition process. The provider is required to fully cooperate with the department's transition team and other state agencies, and must provide full access to agency records and information about the individuals supported. The provider is responsible for facilitating the effective transition of individuals to the agencies of their choice prior to the termination date. The termination date is noted in the letter and funding is no longer available after that point. Case managers also have a role in ensuring the transition process is complete prior to the date of termination. APS could be notified of potential caretaker neglect if the agency under termination is not cooperating."

(b) Response: Department is filing an "amended after comments" regulation with the following provisions regarding voluntary moratoriums:

"Section 17. Voluntary Moratorium. (1)(a) Upon the department becoming aware of a potential health, safety, or welfare violation, the department shall contact the provider's executive director to:
1. Officially notify the provider of the option for a voluntary moratorium; and
2. Discuss the health, safety, or welfare concern.
(b) The department's notice to the provider shall initially be made via phone followed up by notice via electronic means.
(c) Upon receipt of the electronic notice, the provider shall formally accept or not

accept the voluntary moratorium option by:
1. Signing the document provided; and
2. Returning it to the department within two (2) business days of receipt by electronic means as directed in the electronic notice.
(2) If the provider:
(a) Agrees to a voluntary moratorium, the department shall proceed as established in 907 KAR 7:005 regarding a voluntary moratorium pending an investigation; or
(b) Does not agree to a voluntary moratorium, the department shall:
1. Work in conjunction with the department to terminate the provider in accordance with 907 KAR 7:005; and
2. Notify in writing the provider's executive director at the agency's primary business address of the:
a. Reason for termination; and
b. Provider's right to appeal the termination within:
(i) Two (2) business days of receipt of the written non-acceptance of the voluntary moratorium; or
(ii) Five (5) business days of the initial notice sent to the provider if the provider did not respond to the notice of the voluntary moratorium option.
(3) A notice of termination to the provider shall be sent via a delivery method that records the sending and receipt of the notice.
(4)(a) If a provider is terminated, the department shall:
1. Monitor the provider's efforts to ensure the health, safety, and welfare of participants in need of being transitioned to a new provider; and
2. Provide technical assistance to the provider during the transition.
(b) A provider shall:
1. Fully cooperate with the department's transition assistance team and any other state government agency involved;
2. Provide full access to its records and information pertaining to the participants being transitioned; and
(c) Be responsible for facilitating the effective transition of participants to another provider or providers of the participant's choice prior to the termination date.
(d) A provider's termination date shall be stated in the termination notice.
(e) A participant's case manager shall help ensure that the participant's transition to a new provider or providers is completed prior to the termination date."

(15) Subject: Incident Reports

(a) Comment: Therapeutic Intervention Services made the following comment:

"For Critical Incident Reports, the Cabinet has chosen to remove the requirement to notify the Case Manager and Guardian is removed from the regulation. It seems that one of the most important notification when reporting the suspicion of abuse, neglect, and exploitation is APS/CPS and then the guardian.

Additionally in situations of the suspicion of abuse, neglect, and exploitation, the

regulation states that staff makes an immediate report to the MWMA system. This is difficult for any staff providing any community-based services and may not have access to a computer and internet at the time of a critical incident. It seems extremely unrealistic to hold a staff accountable of making this report in the system. There should be a system for staff to make the notifications immediately when they do not have access to the system."

Lisa A Chaplin Wise, Communicare, made the following comment on Section 11 Incident Reporting Process (b) If the critical incident is: 1. One (1) that requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA portal by the individual who witnessed or discovered the critical incident;.:

"Will this be for ALL direct care (over 70 employees), residential (over 200 employees), PDS Employees (over 1500), day training (over 100 employees), etc and if this is a requirement via MWMA who will be providing internet access to ALL people who may witness an incident? How can an incident be immedately reported if the witness and the participant are in the community when the incident occurs? Who will be responsible for managing all employee log in information into MWMA? How much access will be given to employees to view/change/access those incident reports; especially in relation to PDS Employees who are not employed by the agency but rather by the participant? Also consider that the Case management agency will be different than the provider agency due to conflict-free case management. Will ALL providers be given MWMA access to ALL participants they serve? How will this be managed and implemented while continuing to protect participant's privacy rights? Who will be responsible for providing the MWMA portal trainings to each and every person/employee who may need to report an incident in the portal?"

(b) Response: DMS is revising the language in an "amended after comments" regulation as follows:

"(5)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.
(b) If the critical incident:
1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA ~~[portal by the individual who witnessed or discovered the critical incident~~]; or
2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA ~~[portal by the individual who witnessed or discovered the critical incident~~] within eight (8) hours of discovery."

Since the reports are made directly into the portal there is no need for the provision of next business day.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;

Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Requiring incidents to be entered into the MWMA portal by the person who discovered or witnessed the incident is too burdensome. The person will have to come to an office location to access the portal. It would be better if the person completes an incident report form and is permitted to turn it in for the entry by designated agency staff. Requiring critical incidents involving abuse, neglect and exploitation to be entered immediately into the MWMA portal is not feasible as staffed residences and group homes are not equipped with company computers for portal access. This would also be a problem for most family home providers and adult foster care providers. If an incident occurs after hours or on weekends or holidays, staff cannot access the portal to meet the requirement. The same situation applies to the requirement that critical incidents not involving abuse, neglect and exploitation be reported within eight hours. The regulation does not contain provisions for reporting on the next business day or an alternative to entering the incident immediately into the MWMA portal."

(b) Response: DMS is revising the provisions as follows via an "amended after comments" regulation:

(4)(a) If an incident occurs, the Michelle P. waiver provider shall:
1. Report the incident by making an entry into the MWMA [~~portal~~] that includes details regarding the incident; and
2. Be immediately assessed for potential abuse, neglect, or exploitation.
(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:
1. The individual who discovered or witnessed the incident shall immediately act to ensure the health, safety, or welfare of the at-risk participant;
2. The incident shall immediately be considered a critical incident;
3. The critical incident procedures established in subsection (5) of this section shall be followed; and
4. The Michelle P. waiver provider shall report the incident to the participant's case manager and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.
(5)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.

(b) If the critical incident:
1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA [~~portal by the individual who witnessed or discovered the critical incident~~]; or
2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA [~~portal by the individual who witnessed or discovered the critical incident~~] within eight (8) hours of discovery.

Regarding an incident that is not critical, someone at the provider agency must report the incident in the MWMA but it does not have to be the witness to the incident. This will not be required of all staff, only someone at the provider agency.

(16) Subject: Corrective Action Plans

(a) Comment: Tanya L. Dickinson, Program Support Branch Manager/Legislative Coordinator, Department for Behavioral Health, Developmental & Intellectual Disabilities stated the following:

"Comment:
Upon a finding of non-compliance with policies described in Kentucky Administrative Regulations (KAR) regarding a 1915 (c) home or community based services waiver program, the regulation does not clearly specify an allowed period for provider response to a citation(s), provider creation and submission of a Corrective Action Plan(s) (CAP) to the department, provider revision and re-submission of a rejected CAP to the department, , or potential consequences if an acceptable CAP is not ultimately submitted.

Recommendation:
Due to the potential for serious life/safety issues, and increased adverse effects on vulnerable individuals, the provider shall comply with the following requirements for Corrective Action Plans (CAPs): When the provider receives a findings report from the department indicating that issues of non-compliance have been cited, the agency has: Ten (10) business days from the date of the cover letter to submit the CAP per instructions noted in the cover letter. If a provider is notified by the Department that CAP-1 was not approved, the provider shall submit a revised CAP within: Ten (10) business days from the date of the cover letter per instructions noted in the cover letter. If a provider is notified by the Department that CAP-2 was not approved, the Executive Director may request to meet with the Waiver Manager as soon as possible but must submit a revised CAP within: Five (5) business days from the date of the cover letter per instructions noted in the cover letter.

Cited providers shall submit an initial CAP and up to two (2) department-directed revisions (for a total of three (3) submissions). The department's allowable period to review revisions submitted should be thirty (30) business days. (907 KAR 7:005 specifies that the department shall have "thirty (30) days" to review a CAP. This should be clarified to mean thirty (30) business days for consistency.)

Citations are not appealable. If the provider does not submit an acceptable CAP within these guidelines, the department shall recommend to DMS that: the agency not be certified as a new provider agency; the provider certification not be renewed; or the provider certification be terminated. Providers have the option to appeal termination."

(b) Response: DMS is filing an "amended after comments" regulation with the following provisions regarding corrective action plans:

"Section 15. Corrective Action Plans. (1)(a) If a provider receives a findings report from the department indicating that an issue of non-compliance has been cited, the provider shall have ten (10) business days from the date on the letter that accompanied the findings report to submit a corrective action plan to the department in accordance with the instructions in the letter.
(b) If a provider is notified by the department that the corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within ten (10) business days of the date on the letter informing that the initial corrective action plan was not approved and in accordance with the instructions in the letter.
(c)1. If a provider is notified by the department that the second corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within five (5) business days from the date on the letter notifying that the second corrective action plan was not approved.
2. If the third corrective action plan submitted to the department is not approved, the department shall:
a. Not certify the provider if the provider is new;
b. Not recertify the provider if the provider is an existing provider; or
c. Terminate the provider's certification.
3. A provider shall have the right to appeal a termination in accordance with 907 KAR 1:671.
4. A citation of an issue of non-compliance shall not be appealable.
(2) The department shall have up to thirty (30) business days to review a corrective action plan."

(17) Subject: Regulatory Impact Analysis

(a) Comment: Jean Russell, Vice President, Developmental Services, Seven Counties Services, Inc., stated the following:

"This document indicates there are not any additional costs imposed on providers through these regulatory changes. We would request the analysis done to support this statement be made public. As stated previously, the implementation of the MWMA portal has had a significant financial impact on all providers because of the amount of duplication of effort required."

(b) Response: DMS is implementing the MWMA portal in concert with the Kentucky

Office of the Health Benefit and Information Exchange (KOHBIE) to automate and streamline processes associated with home and community based waiver programs. Currently the processes include a combination of manual, paper-based, and automated systems but the MWMA portal will standardize and streamline the processes and tools that support the home and community bases waiver programs. DMS believes that in the long term the MWMA portal will prove to be cost effective for providers.

Additionally, DMS believes that MWMA will improve care coordination and delivery of services to individuals and their families as well expedite processes and actions and allow for information to be preserved and updated much easier online where it is also readily accessible to the appropriate parties.

(18) Subject: Proposed Changes

(a) Comment: Jodi Wilson, Regional Director – Kentucky, Rescare, made the following comment:

“I am concerned that individuals included in this waiver will suffer decline and experience increased challenges due to the proposed changes in this waiver that include maximum units avaliable and specifics regarding who, can do what for them, in what manner. I remain extremely concerned the waiting list remains large without indication of improvement or resolution. The persons supported in this waiver and their families did not ask for the challenges they face. We should not add to their burden further with waiver changes that do not result in improved quality of life for them all.”

(b) Response: DMS staff recommends other waiver programs to individuals on the waiting list while the individuals wait for a slot to become available. We also ask that the community mental health centers recommend other waivers or programs that the individuals could explore to see if they would qualify for services. DMS understands that the Michelle P. waiver waiting list has several members on the list; however, we are only able to assign slots when they are given to DMS for allocation. We welcome any comments or recommendations from providers and will consider them during the waiver renewal process next year.

(19) Subject: Definitions

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 1 Definitions under “Support Broker”, b) Assist the[a] consumer in any other aspects of PDS[CDO].”:

“"'Consumer" should be updated to match consistency throughout document with "participant"”.

(b) Response: Thank you. Via an “amended after comments” regulation DMS is changing the term “consumer” to “participant” in the definition of support broker as well as correcting the term in Section 7(5)(b)3 and Section 7(6).

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 1 Definitions under “Support Spending Plan”, "(h) Six (6) month budget."

“The PDS budget and PA are based on a one-year approval which is contradicted later in the regulation when it cites a 12 month budget for PDS Services: "(13)(a) The department shall establish a twelve (12) month budget for a participant[consumer] based on the participant's person-centered service [consumer's] plan [of care]." Please clarify regulation for either the 6 month budget or 12 month budget.”

(b) Response: Thank you for the comment. Via an “amended after comments” regulation DMS is changing the budget period from six (6) months to twelve (12) months.

(20) Subject: Adult Day Training Service

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 6 Covered Services Adult Day Training Service under (i) An enclave or group approach to training in which recipients work as a group or are dispersed individually throughout an integrated work setting with people without dis-abilities; AND (iii) An entrepreneurial or group approach to training for participants to work in a small business created specifically by or for the:

“"Recipients" should be updated to match consistency throughout document with "participant"”.

(b) Response: Thank you for your comment. Via an “amended after comments” regulation DMS is correcting the term from “recipient” to “participant” in several overlooked places.

(21) Subject: Waiting List

(a) Comment: Lisa A Chaplin Wise, Communicare, made the following comment on Section 12 Michelle P Waiver Program Waiting List (5) At least annually, the department shall contact each individual, or individual's legal representative, on the Michelle P. Waiver Program waiting list:

“Will this process be similar to the current SCL Waiting list annual update process? If so, when will annual updates occur: during the participant's birth month or one year after app lying for the waiting list? Will these letters be sent to the provider that submitted the MPW Waiting list application, will they be sent directly to the participant with their responsibility to return, or will they be issued to the participant via MWMA?”

(b) Response: The Michelle P. waiver waiting list process is different from the SCL waiting list process. There is a one-time mailing for the annual update that is mailed to the participant, guardian, or legal representative.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Kentucky Association of Private Providers (KAPP) currently has 74 provider members and 6 associate members. This is the largest membership of KAPP's 33---year existence, representing a blend of non---profit and for---profit providers, ranging from the Commonwealth's smallest to largest service provider agencies. We are currently conducting a demographic study, but at last count KAPP members provided support for over 75% of all waiver recipients in Kentucky.

With over 2,700 people under 21 (over 2,000 of those under age 16) in the Michelle P. Waiver (due to the continued use of an adult assessment tool, the Map 351) Kentucky finds itself in the following predicament:

• There are now 4,300 people on the waiting list (for a waiver established to alleviate a waiting list.)
• 70% of those on the waiting list are under 21 years of age. Kentucky has continued to use an inappropriate assessment tool even though it was identified as a problem nearly 3 years ago. Acting Commissioner of DBHDID, Betsy Dunnagin, at a House Bill 144 Commission Meeting in 2013, discussed it. More recently, a recommendation was made by the Medicaid Technical Advisory Committee (TAC) to the Medicaid Advisory Committee (MAC) to secure an appropriate tool to assess children. Earlier this month, a committee recommendation was again made to the House Bill 144 Commission that an appropriate tool must be found and asked for an update on the process of securing one."

(b) Response: At this time, DMS will continue to use the MAP-351 to assess participants and does not have a separate assessment tool for children. DMS will be exploring more age-appropriate tools but has not made a change at this time.

(a) Comment: Chris Stevenson, President and CEO of Cedar Lake in Louisville, made the following comment:

“We just ask that – we urge the Cabinet to expedite the review of an appropriate assessment tool to serve these children and, also, of course, the adults that that assessment tool was created for. There’s going to be significant challenges all the while creating this. And we just ask for full consideration to expedite the process; one of them being to, of course, identify an appropriate assessment tool; and that’s a challenge in and of itself.

Secondly, there’s going to need to be approval from CMS as part of the Waiver renewal or amendment. Again, more time and consideration. And, then, ultimately, the challenge is going to be to develop a transition plan for those receiving services that are currently inappropriately being assessed. So, I just wanted to go on record again that it is so important to develop an appropriate tool and to get the adults who were intended to get these services get the services that they need.”

(b) Response: The Cabinet agrees with the need to explore and identify an appropriate assessment tool for children as well as adults and will be doing this as part of the waiver renewal process next year.

(22) Subject: What to Expect in Billing Audits

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“In August 2015, on a DDID provider teleconference, Lyris Childs from the Michelle P. Waiver program did a presentation on What to Expect in MPW Billing Audits.

Providers asked many questions about the outdated regulation, specifically surrounding the Case Management Face---To---Face requirements. Providers are concerned that those issues have still not been addressed, even in this revision.

Providers were expecting an FAQ after that webinar within 14 business days, which would have been August 26, 2015. Providers were told via email on August 26th, that the FAQ’s would be forthcoming at a later date. As of this writing, those have not been provided to agencies. Providers are optimistic that the delay could mean the Cabinet is working on a solution.”

(b) Response: Thank you for your input and comments. DMS will be renewing the waiver next year and will bear these concerns in mind.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the Stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Providers are concerned that the presentation on What to Expect in Billing Audits, referencing the outdated waiver, is preparing them for a major recoupment. Providers have been simply serving the participants that have been assessed into the waiver using the Map 351 Assessment Tool. If the only regulation providers have to utilize for their services, do not accurately suit them, then what do providers do? Deny services? Providers have been serving the people in the waiver per the existing regulation, the best they can. If there are problems with services and documentation, the Cabinet also bears responsibility."

(b) Response: Thank you for your input and comments. DMS will be renewing the waiver next year and will bear these concerns in mind.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR:1:835 and is amending the administrative regulation as follows:

Page 7
Section 1(30)
Line 6
After "'MWMA", delete "portal".

Page 8
Section 1(35)

Line 3
After “allows”, insert “participants”.
Delete “recipients”.

Page 10
Section 1(51)(b)
Line 6
After “the”, insert “participant”.
After “[a]”, delete “consumer”.

Page 10
Section 1(52)(h)
Line 20
After “(h)”, insert “Twelve (12)”.
Delete “Six (6)”.

Page 10
Section 2
Line 22
Before “Section 2.”, insert the following:
(54) “Voluntary moratorium” means a provider’s voluntary agreement to not serve any new (to the provider) 1915(c) home and community based waiver services participants.

Page 11
Section 2(1)(b)
Line 7
After “department”, insert the following:
in accordance with 907 KAR 12:010

Page 11
Section 2(2)(a)5.
Line 19
After “164;”, delete “and”.

Page 11
Section 2(2)(a)6.
Line 20
After “1320d-8;”, insert the following:
and
7. The provider participation requirements for SCL providers established in 907 KAR 12:010, Section 3;

Page 11
Section 2(2)(b)
Line 21

After “a”, insert “participant”.
Delete “Michelle P. waiver recipient”.

Page 11
Section 2(2)(c)
Line 23
After “a”, insert “participant”.
Delete “Michelle P. waiver recipient”.

Page 12
Section 3(1)(a)
Line 10
After “MWMA”, delete “portal”.

Page 14
Section 4(2)(a)
Line 22
Before “; and”, delete “portal”.

Page 14
Section 4(2)(b)
Line 23
After “MWMA”, delete “portal”.

Page 21
Section 6(3)(c)4.
Line 13
After “note”, insert “in the MWMA”.

Page 22
Section 6(3)(d)3.
Line 12
After “note”, insert “in the MWMA”.

Page 23
Section 6(3)(e)5.
Line 4
After “note”, insert “in the MWMA”.

Page 24
Section 6(3)(f)4.
Line 2
After “note”, insert “in the MWMA”.

Page 24
Section 6(3)(g)4.

Line 17
After “note”, insert “in the MWMA”.

Page 25
Section 6(3)(h)4.
Line 7
After “MWMA”, delete “portal”.

Page 25
Section 6(3)(h)5.
Line 8
After “note”, insert “in the MWMA”.

Page 25
Section 6(3)(i)6.
Line 22
After “note”, insert “in the MWMA”.

Page 26
Section 6(3)(j)6.
Line 15
After “note”, insert “in the MWMA”.

Page 27
Section 6(3)(k)5.
Line 6
After “note”, insert “in the MWMA”.

Page 28
Section 6(3)(l)6.d.
Line 12
After “the”, insert “participant”.
Delete “recipient”.

Page 28
Section 6(3)(l)6.e.(i)
Line 15
After “which”, insert “participants”.
Delete “recipients”.

Page 28
Section 6(3)(l)6.e.(iii)
Line 20
After “the”, insert “participant”.
Delete “recipient”.

Line 21
After “or”, insert “participants”.
Delete “recipients”.

Page 29
Section 6(3)(l)11.
Line 10
After “documented”, insert “in the MWMA”.

Page 30
Section 6(3)(m)8.
Line 11
After “documented”, insert “in the MWMA”.

Page 32
Section 6(3)(n)9.
Line 15
After “documented”, insert “in the MWMA”.

Page 36
Section 6(3)(p)6.
Line 2
After “documented”, insert “in the MWMA”.

Page 40
Section 7(5)(b)3.
Line 21
After “the”, insert “participant”.
Delete “consumer”.

Page 40
Section 7(6)
Line 23
After “A”, insert “participant”.
Delete “consumer”.

Page 42
Section 7(10)(b)
Line 10
After “Section”, insert “19”.
Delete “16”.

Page 42
Section 7(11)(h)
Line 22
After “check”, insert the following:

from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to being a PDS provider

Page 43
Section 7(11)(i)1.
Line 2
After “registry;”, delete “and”.

Page 43
Section 7(11)(i)2.
Line 3
After “Registry;”, insert “maintained”.

Line 4
After “registry;”, insert the following:
and
3. Central Registry maintained in accordance with 922 KAR 1:470 and not be found on the registry;

Page 45
Section 8, Title
Line 11
Before “Section 8.”, insert the following:
(17) Services provided by a support broker shall meet the conflict free requirements established for case management in Section 9(4)(f) and Section 9(5) of this administrative regulation.

Page 49
Section 8(4)(a)1.
Line 3
After “MWMA”, delete “portal”.

Page 49
Section 8(4)(a)2.
Line 4
After “MWMA”, delete “portal”.

Page 49
Section 8(4)(b)
Line 6
After “MWMA”, delete “portal”.

Line 7
After “MWMA”, delete “portal”.

Page 52
Section 9(2)(m)
Line 20
After “MWMA”, delete “portal”.

Page 53
Section 9(2)(n)
Line 6
After “MWMA”, delete “portal”.

Page 54
Section 9(3)(a)
Line 1
After “MWMA”, delete “portal”.

Page 54
Section 9(3)(b)
Line 3
After “MWMA”, delete “portal”.

Page 55
Section 9(5)(b)2.d.
Line 20
After “MWMA”, delete “portal”.

Page 58
Section 11(4)(a)1.
Line 1
After “MWMA”, delete “portal”.

Page 58
Section 11(5)(b)1.
Line 19
After “MWMA”, delete the following:
portal by the individual who witnessed or discovered the critical incident

Page 58
Section 11(5)(b)2.
Line 22
After “MWMA”, delete the following:
portal by the individual who witnessed or discovered the critical incident

Page 59
Section 11(5)(c)2.
Line 4

After “MWMA”, delete “portal”.

Page 59
Section 11(6)(a)
Line 15
After “MWMA”, delete “portal”.
Page 61
Section 11(7)(a)
Line 1
After “MWMA”, delete “portal”.

Page 63
Section 12(2)(a)
Line 19
Before “; and”, delete “portal”.

Page 63
Section 12(2)(b)
Line 20
After “MWMA”, delete “portal”.

Page 68
Section 15, Title
Line 1
After “15.”, insert the following:

Corrective Action Plans. (1)(a) If a provider receives a findings report from the department indicating that an issue of non-compliance has been cited, the provider shall have ten (10) business days from the date on the letter that accompanied the findings report to submit a corrective action plan to the department in accordance with the instructions in the letter.

(b) If a provider is notified by the department that the corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within ten (10) business days of the date on the letter informing that the initial corrective action plan was not approved and in accordance with the instructions in the letter.

(c)1. If a provider is notified by the department that the second corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within five (5) business days from the date on the letter notifying that the second corrective action plan was not approved.

2. If the third corrective action plan submitted to the department is not approved, the department shall:

a. Not certify the provider if the provider is new;

b. Not recertify the provider if the provider is an existing provider; or

c. Terminate the provider’s certification.

3. A provider shall have the right to appeal a termination in accordance with 907 KAR 1:671.

4. A citation of an issue of non-compliance shall not be appealable.
(2) The department shall have up to thirty (30) business days to review a corrective action plan."
Section 16. Provider Certification. The following shall apply regarding Michelle P. waiver provider certification periods:

Provider Status at Recertification Date	New Certification Period Based on Status at Recertification Date
Zero citations during the most recent recertification review and have successfully implemented any approved corrective action plan for any citation issued during the recertification period if any citation was issued	One (1) year
Received citations during the most recent recertification review or has existing (open) citations without either an accepted corrective action plan or a successfully implemented corrective action plan	Six (6) Months (1) Upon approval of corrective action plan, the department shall monitor for successful implementation within thirty (30) days. (2) Upon successful implementation of corrective action plan, the department shall extend recertification to balance of one (1) year. (3) If provider fails to implement an approved corrective action plan, the department shall extend the timeframe for implementation or consider non-renewal or termination. (4) If provider has not submitted an approved corrective action plan after the three (3) allowed attempts (see above), the department shall consider non-renewal or termination.

Section 17. Voluntary Moratorium. (1)(a) Upon the department becoming aware of a potential health, safety, or welfare violation, the department shall contact the provider's executive director to:
1. Officially notify the provider of the option for a voluntary moratorium; and
2. Discuss the health, safety, or welfare concern.
(b) The department's notice to the provider shall initially be made via phone followed up by notice via electronic means.
(c) Upon receipt of the electronic notice, the provider shall formally accept or not accept the voluntary moratorium option by:

1. Signing the document provided; and
2. Returning it to the department within two (2) business days of receipt by electronic means as directed in the electronic notice.
(2) If the provider:
(a) Agrees to a voluntary moratorium, the department shall proceed as established in 907 KAR 7:005 regarding a voluntary moratorium pending an investigation; or
(b) Does not agree to a voluntary moratorium, the department shall:
1. Terminate the provider in accordance with 907 KAR 7:005; and
2. Notify in writing the provider's executive director at the agency's primary business address of the:
a. Reason for termination; and
b. Provider's right to appeal the termination within:
(i) Two (2) business days of receipt of the written non-acceptance of the voluntary moratorium; or
(ii) Five (5) business days of the initial notice sent to the provider if the provider did not respond to the notice of the voluntary moratorium option.
(3) A notice of termination to the provider shall be sent via a delivery method that records the sending and receipt of the notice.
(4)(a) If a provider is terminated, the department shall:
1. Monitor the provider's efforts to ensure the health, safety, and welfare of participants in need of being transitioned to a new provider; and
2. Provide technical assistance to the provider during the transition.
(b) A provider shall:
1. Fully cooperate with the department's transition assistance team and any other state government agency involved;
2. Provide full access to its records and information pertaining to the participants being transitioned; and
3. Be responsible for facilitating the effective transition of participants to another provider or providers of the participant's choice prior to the termination date.
(c) A provider's termination date shall be stated in the termination notice.
(d) A participant's case manager shall help ensure that the participant's transition to a new provider or providers is completed prior to the termination date.
Section 18.

Page 68
Section 16, Title
Line 7
Renumber this section by inserting "19." and by deleting "16.".

Page 69
Section 17, Title
Line 2
Renumber this section by inserting "20." and by deleting "17.".

Page 69

Section 17(1)(c)
Line 6

After “Exemption,’, insert “<u>October</u>”.

Delete “May”.